

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
HEALTH CARE FINANCING ADMINISTRATIONTO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:

01-001

2. STATE:

ALABAMA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

Title XIX of the Social Security Act

4. PROPOSED EFFECTIVE DATE

February 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 C.F.R. 430 Subpart B

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-E pg. 1  
Attachment 4.10-B pg. 10

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 200,000.00

b. FFY 2002 \$ 200,000.00

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

The purpose of this State Plan Amendment is to add liver/small bowel and small bowel  
transplants to covered transplants for all ages.

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:Governor's designee on file  
via letter with HCFA

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Michael E. Lewis

14. TITLE:

Commissioner

15. DATE SUBMITTED:

January 19, 2001

16. RETURN TO:

Michael E. Lewis  
Commissioner  
Alabama Medicaid Agency  
501 Dexter Avenue  
Post Office Box 5624  
Montgomery, AL 36103-5624**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

January 22, 2001

18. DATE APPROVED:

February 5, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

February 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Eugene A. Granger

22. TITLE:

Associate Regional Administrator  
Division of Medicaid and State Operations

23. REMARKS:

State: Alabama

## STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

**Effective Date: 02/01/01**

Transplant services and associated immunosuppressive drugs are covered by the Alabama Medicaid Agency as defined below:

Group I includes medically necessary corneal transplants and does not require prior approval. These services are limited to routine benefit and payment limitations.

Group II includes medically necessary heart, lung, heart/lung, liver, liver/small bowel, small bowel, kidney, pancreas, and pancreas/kidney transplants. All transplants in this group require prior approval based on medical criteria contained in the Alabama Medicaid Transplant Manual. In order to be approved, transplants must be therapeutically proven effective and considered nonexperimental, and are limited to within the geographic boundaries of the State of Alabama. If there is no in-state transplant facility that has the medical expertise/staffing to perform the transplant, Medicaid may approve the transplant to be performed out of state.

Group III includes medically necessary bone marrow transplants which require prior approval. Approval is based on medical criteria contained in the Alabama Medicaid Transplant Manual. Bone marrow transplants must be therapeutically proven effective and considered nonexperimental, and are limited to within the geographic boundaries of the State of Alabama. If there is no in-state transplant facility which has the medical expertise/staffing to perform the transplant, Medicaid may approve the transplant to be performed out of state.

Group IV includes any medically necessary nonexperimental EPSDT-referred organ transplants. These include transplants which have been determined to be nonexperimental and necessary to treat or ameliorate a condition identified in a screening.

Procedures must be performed at a transplant center in which transplants are routinely performed by an integrated team of surgeons and medical support staff and which is in compliance with all applicable federal, state or local laws regarding organ acquisition and transplantation, equal access and nondiscrimination.

Payment methodology for bone marrow, liver, liver/small bowel, small bowel, lung, heart/lung, heart, kidney, pancreas, and pancreas/kidney transplants is outlined in Attachment 4.19-B in the State Plan.

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TN No. AL-01-01

Supersedes

TN No. AL-00-03

Approval Date FEB 05 2001

Effective Date 02/01/01

Providers will be paid at the lesser of charges or a global payment for EPSDT referred non-experimental organ transplants. Global payment includes pre-transplant evaluation; organ procurement; all transplant services including hospital room, board and ancillaries, inpatient post-operative care and professional fees. Global payment maximums are \$150,000.00 for a heart/lung transplant, \$100,000.00 for a kidney/pancreas transplant and \$135,000.00 for a lung transplant.

Any other medically necessary EPSDT referred non-experimental organ transplants will be paid at the lesser of charges or a global payment determined by the Agency. Payment amounts are determined by review of charges made by transplant centers performing the transplant to determine an amount that is reasonable and adequate to secure the required transplant service.

**Effective Date: 02/01/01**

As an alternate payment methodology to the above, Medicaid may use an approved prime contractor. Medicaid's approved prime contractor will be responsible for the coordination of and reimbursement for all Medicaid reimbursable organ transplants with the exception of cornea transplants. Payments to providers for heart, lung, heart/lung, kidney, pancreas, kidney/pancreas, liver, small bowel, liver/small bowel and bone marrow transplants shall be made based on the lesser of the charge for the service or the fixed global fee specified by Medicaid based on reasonable cost. This global payment includes pre-transplant evaluation, organ procurement, hospital room, board, and all ancillary costs both in and out of the hospital setting, inpatient postoperative care, and all professional fees. These payment maximums in no case shall exceed amounts customarily paid for comparable services under comparable circumstances. These services are not counted toward a recipient's routine benefit limits.

19. Payment of Title XVIII Part A and Part B Deductible/  
Coinsurance

**Effective Date: 11/10/97**

Reimbursement for Part A nursing home claims shall be based on the coinsurance amount due minus prorated recipient liabilities not to exceed the Medicaid per diem rate. Recipient liabilities will not be applied to QMB eligibles.

No payments made pursuant to the methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR §447, Subpart F.